

Fig 2

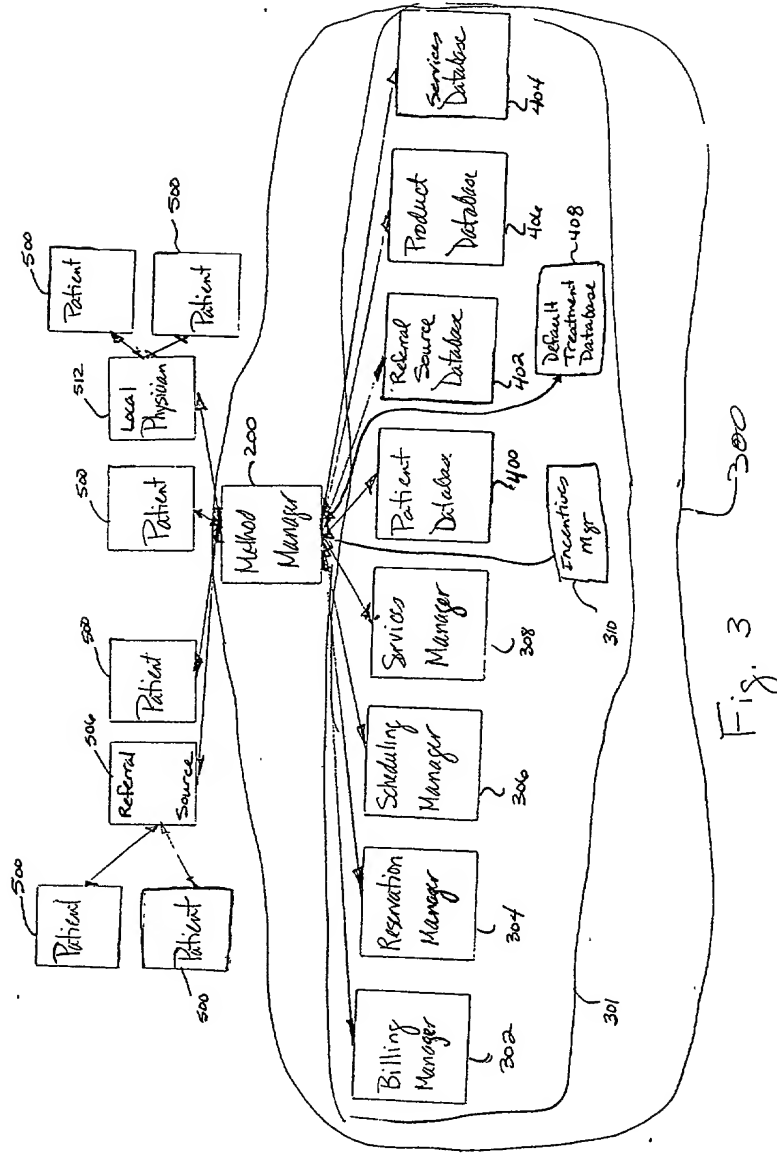


Fig. 3

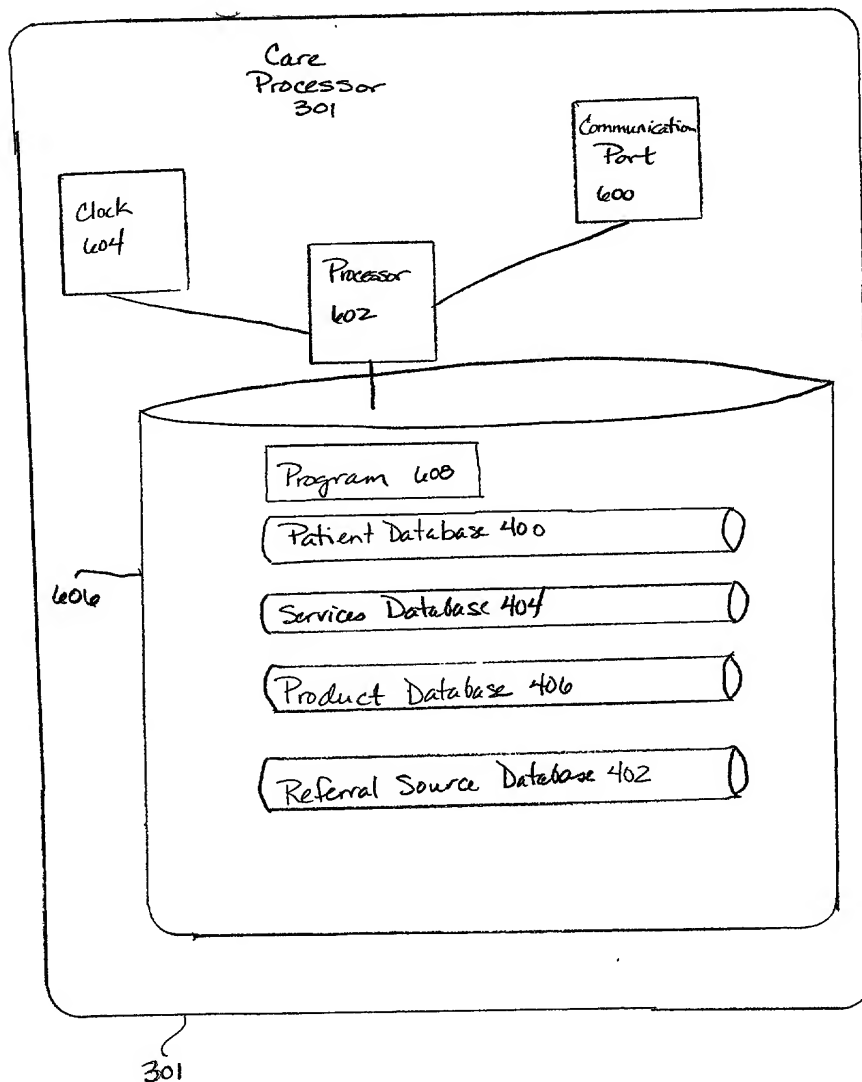


FIG. 4

Patient Identifier 614	Patient Name 618	Patient Address 620	Geographical Location for Treatment and/or After Care 622	Medical Facility Identifier 624	Local Physician Identifier 626	Local Physical Contact Information 628	TPA/Insurance Company Identifier 630	Home Physical Identifier 632	Home Physician Contact Information 634	Expected Start Date Identifier 636	Expected Stop Date Identifier 640	Expected Length of Stay and Accommodation 642	Medical Procedure or Care Identifier 644

An Accommodation Preferences Identifier 646	Concierge Services Preferences 648	Personal Emergency Contact Information 650	Billing Status Identifier 652	Referral Source Identifier 654	Bundle Identifier 656	Resumption Identifier 658	Patient Birth Date 659	Patient Sex Identifier 660	Patient Allergies 662	Anniversary of the Procedure/Recovery 664	Default After Care Protocol and Notes 666	Prescribed After Care Protocol and Notes 668	Medical Record Information 669

FIG. 5

Referral Source Identifier 654	Referral Source Name 672	Referral Source Contact Information 674	Billing Type Information 676	Billing Status Information 652	Incentive Information 680	Client Patient Identifier Information 614	Medical Procedure or Care Identifier 644	Incentives Received Identifier 678	Incentives Due Identifier 682	Referral Information 683

Fig. 6

209050" 2302900T

Patient Identifier 614	Patient Name 618	Reservation Code 616	Bundle Identifier 656	Service Type Identifier 692	Service Provider Identifier 690	Time Identifier 694	Date Identifier 696	Cost Identifier 698	Billing Status Identifier 652

FIG. 7

202050" 23023001

Product Identifier	Product Price	Availability Identifier	Product Ingredients	Prescribed Uses for the Product	Medical Procedure or Treatment Identifier	Provider Identifier
704	706	708	710	712	644	714

FIG. 8

Medical Procedure or Treatment Identifier	Medication Type Identifier	Medication Dosage Identifier	Treatment Type Identifier	Treatment Practice Identifier
644	724	726	728	730

FIG. 9

209090" 48049007

PRACTICE PROFILE

Prepared by: _____		Date: _____		Referral Potential				Attitude	
				Q1	Q2	Q3	Q4		
Institution				Pats					
Location				Tel. (Switch)					
Address				Fax					
City		State		Zip		Website			
Key Personnel									
Contact	Title	First name	Initials	Last Name	Position Title				
Types and Volumes of Patients					Services Required		Special Needs		
Referral Process					Agreed Action (What)		Who?	When?	
Marketing Process					Agreed Action (What)		Who?	When?	
Training Process					Agreed Action (What)		Who?	When?	
Relationship Building					Agreed Action (What)		Who?	When?	

F16.10

FIG. 11A

TITLE: TUBE FEEDING MANAGEMENT PROTOCOL

PURPOSE: To outline the nursing management of patients receiving continuous, intermittent, or cyclic enteral tube feedings via nasogastric, gastrostomy, duodenostomy, or jejunostomy tube.

LEVEL OF PERSONNEL: RN LPN

- PURPOSE:** Tube feedings are employed to meet nutritional needs including hydration requirements when normal oral intake is altered or contraindicated. The potential for tube displacement puts these patients at risk for aspiration pneumonia, or peritonitis.
- MD ORDER**
1. Validate that tube feeding order states formula, volume, strength, rate, time span, and method of delivery (i.e. continuous, cyclic, bolus or gravity drip).
 2. Measure, at time of feeding tube insertion, the length of visible tube and record on NPR.
- ASSESSMENT**
4. Assess for tube placement q 8 hours and before each intermittent feeding or medication administration, using at least two of the following measures:
 - a. measure and compare length of visible tube to initial measurement
 - b. aspirate gastric or small bowel contents (5-10ml, observe for appropriate color and consistency)
 - c. instill 10 ml of air into tube while auscultating stomach (gastric only)
 5. Assess gastrostomy/jejunostomy site q 24 hours for:
 - a. leakage of formula around tube
 - b. signs of infection (redness, induration, purulent drainage)
 6. Assess patient's fluid balance q 24 hours:
 - a. compare I/O, note fluid imbalances
 - b. monitor weight changes
 - c. monitor lab values (electrolytes, BUN, Cr.)
 7. Assess general abdominal/digestive status q 8 shift:
 - a. assess bowel sounds
 - b. observe for signs/symptoms of feeding intolerance: repeated nausea/vomiting, cramping, diarrhea or gastric residual >100ml/1 hour.

10067087 "050602

FIG. 11B

REPORTABLE
CONDITIONS

8. Weigh patient q AM, unless otherwise ordered.
9. Maintain I&O q 8 hours.
10. Report promptly to MD:
 - a. suspected displacement of feeding tube
 - b. suspected aspiration, i.e. SOB, elevated temperature
 - c. obstruction of feeding tube
 - d. abdominal distention, nausea/vomiting, cramping, diarrhea, constipation
 - e. fluid-electrolyte imbalance
 - f. gastric residual >120 ml for 2 hours for adults,
0-3 month >30, 3-12 months >45, 14yr+ > 60,
if on bolus > 1/3 of previous feed.
 - g. suspected formula leakage around gastrostomy or
jejunostomy
 - h. temperature >101°F.
11. Administer all formulas at room temperature.
12. Elevate HOB 45 degrees during feeding and for 1 hour following
bolus or gravity feed.
13. Flush tube with 5ml for pedi, 10 ml for adult of warm water when
feeding is interrupted, stopped, or after each intermittent feeding.
14. Flush tube q 4 hours with 5ml of warm tap water if feeding is
continuous.
15. Stop gastric tube feeding if patient is placed flat or in Trendelenberg.
16. Measure gastrostomy residual q 4 hours or before every intermittent
feeding:
 - a. if residual is > 100 ml, HOLD feeding for 1 hour.
 - b. Recheck residual, if still > than 100 ml, HOLD and notify
MD.
Reinstall aspirate.
17. Hold feeding for 1 hour if patient is nauseated, vomiting, or
abdominal distention is present, if symptoms do not improve, notify
MD.
18. Only hang a 4 hour supply of formula, do not leave open formula
containers at room temperature for more than 1 hour.
19. Change formula bag/tubing q 48 hours.

INFECTION

100637087.050602

FIG. 12A

TITLE: VENIPUNCTURE FOR BLOOD SAMPLING

LEVEL OF PERSONNEL: RN, LPN,

DESIGNATED CLINICAL AREA: All

PURPOSE: To obtain routine blood samples.

APPLICABLE POLICY STATEMENTS:

Individuals must successfully complete the training program to perform venipuncture for blood sampling.

A physician's order must be obtained for each test.

CRITICAL ELEMENTS:

1. Use of site in antecubital fossa is preferred if a vein is easily palpable. If a vein is not easily identified, sites in the lower arm or hand may be used, but only as a last resort.
2. Blood samples should not be drawn from an arm with a continuous IV infusion. For patients who should not have venipuncture performed in one arm, notify RN caring for patient, if applicable. IV infusion should be turned off in order to be able to draw blood.

EQUIPMENT:

Venject (may substitute a #23 gauge butterfly needle and syringe)
Appropriate specimen tube with labels
Alcohol swabs
Gauze sponge
Tourniquet
Disposable gloves
Plastic bags for specimen transport
Appropriate lab requisitions

NURSING ACTIONS:

1. Identify the patient.
2. Position patient's arm.
3. Select site for venipuncture. (Figure 1)
4. Apply tourniquet proximal to chosen site.

SPECIAL CONSIDERATIONS:

4. Vein should be distinct-easily visible

10067087.050602

FIG. 12B

and/or palpable. Tourniquet should be tight enough to obstruct venous flow, but, not arterial flow (radial pulse should be palpable).

If vein is not prominent:

- a. Have patient open and close hand, making a fist, no more than 2 times.
- b. Lightly tap vein site.
- c. Take tourniquet off, then place extremity in a dependent position for a few minutes.
- d. If necessary, apply moist heat for a few minutes.
- e. Reapply tourniquet.
5. Cleanse site and surrounding area with alcohol. Repeat if skin is unusually soiled. Using second clean alcohol sponge, wipe the site once with a downward stroke.
6. Put on gloves.
7. Stabilize the extremity and using thumb, hold skin taut below prepped area just distal to intended puncture site.
8. At a 15 degree angle, insert the needle, bevel up, through the skin parallel to vein.
- a. Opening and closing the fist more than 2 may increase lactic acid.
- c. Promotes venous distention.
- d. Use wash cloth moistened with warm tap water.
5. Allow to air dry completely to prevent burning at site and prevent hemolysis. Alcohol mixing with blood causes hemolysis.
8. Parallel approach decreases rolling of vessel.

209050 " 050602

FIG. 12C

NURSING ACTIONS:

9. Butterfly needle:
Withdraw desired amount of blood
and then release tourniquet.

Straight needle with vacutainer:
Remove tube immediately after filling
And insert next tube.
- 10a. Recommended order of filling multiple
tubes:
 - 1) Blood Cultures
 - 2) Red top-no anticoag
 - 3) Blue top
 - 4) Purple top
 - 5) Gray top
 - 6) Green top
- 10b. Invert the tubes gently about 10 times.

Withdraw desired amount of blood
(ie., last tube almost filled). Then
release tourniquet.
11. When using the vacutainer, remove tube
from needle holder to relieve vacuum
before removing needle from vein.
12. Place gauze sponge over puncture site,
remove needle and then apply pressure
over site until bleeding stops. Ask patient
to keep arm straight.
13. Check venipuncture site before leaving
room.
14. If butterfly needle and syringe is used,
place blood in appropriate specimen tubes
following above recommended guidelines.
Label tubes, place in bags and send to lab
with appropriate requisition.

SPECIAL CONSIDERTIONS:

9. Release of tourniquet prior to
removal of needle prevents extravasation
of blood into tissue or excessive bleeding
from puncture site.

Release of tourniquet just before blood
Drawing is complete allows for a last
"surge" of blood into specien tubes.
However, if blood flow is sluggish, it is
best to leave tourniquet in place until the
desired amount of blood is obtained.
- 10a. The rule is to alawys collect blood in
the tube containing anticoagulant last.
- 10b. Blood needs to be mixed with the
additive in the tube for it to function
properly.
12. Bending the arm might cause a
hematoma.
13. If hematoma develops, apply warm
Moist soaks with wash cloth.

10067087 "050602"

FIG. 12D

NURSING ACTIONS:

14. If butterfly needle and syringe is used, place blood in appropriate specimen tubes following above recommended guidelines. Label tubes, place in bags and send to lab with appropriate requisition.

SPECIAL CONSIDERATIONS:

REFERENCES:

Brunner and Suddarth (1988). Textbook of Medical-Surgical Nursing, (6th Edition). Philadelphia, PA: J.B. Lippincott, p. 668.

College of American Pathologists (1996). So You're Going to Collect a Blood Specimen. An Introduction to Phlebotomy. College of American Pathologists, Illinois.

Logston, Boggs, R., Woodridge-King, M. (1993). AACN Procedure Manual For Critical Care. Philadelphia, PA: W. B. Saunders Company.

Milliam, Doris, A. (1987). Venous Blood Samples - Sharpen Your Drawing Skills. Nursing 87, December, p. 56 - 61.

) Nursing Procedures, second edition, (1996). Springhouse. Springhouse, PA

EXPERT RESOURCES:

Mary Liz Bilodeau, RNC, MS, CCRN
Critical Care CNS

Martha Martin, RN, MSN
Staff Specialist

Jill Pedro, RN, MSN, ONC
Clinical Nurse Specialist

PRACTICE AREA:

Department of Nursing

Department of Nursing

Department of Nursing

) Approved: Council on Practice
Revised: Council on Practice /

14067087-050602

FIG. 12E

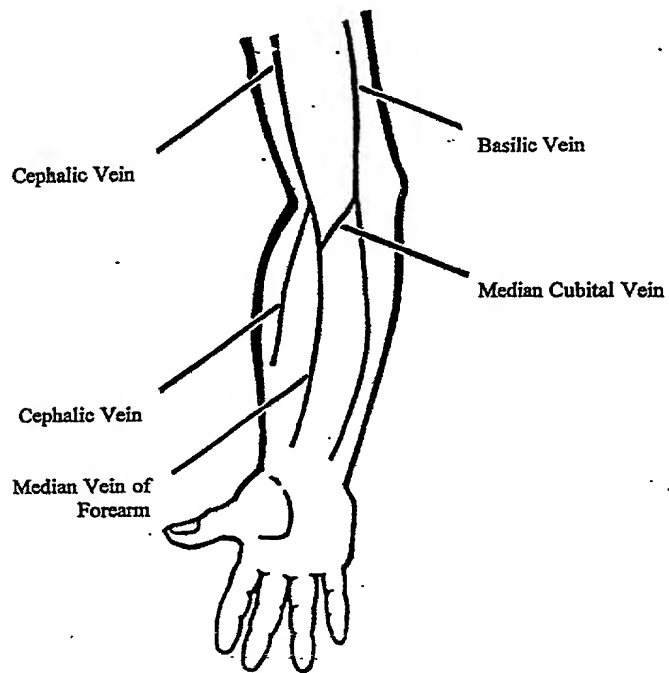


FIGURE 1 - Major Veins in Upper Extremity

209050 " 48049007

Name:		First	Initials	Last	Contact Telephone No.
		mm	day	yr	time
Outward trip				am/pm	Service Required:
From				To	
Address				Address	
State		Zip code		State	Zip code
		mm	day	yr	time
Return trip				am/pm	Service Required:
From				To	
Address				Address	
State		Zip code		State	Zip code
Notes on Required Nursing Services					
Patient Information					
Address:					
City:					
State:					
Zip:					
Phone - Home:					
Work:					
Cell:					
email address:					
Fax:					
Payment Guarantor Information					
Name:		First	Initials	Last	
Address:					
City:		State:		Zip:	
Phone - Home:		Work:		Cell:	
email address:				Fax:	
Payment		Method		Credit Card Type	
Agreed fee for above services		Cash		Amex	
\$		Check		Visa	
		Invoice Company		Card Number	
		Other		Issuer	
				Exp. Date	
				Cardholder name shown on card	

FIG. 13

10067087-05060P

To receive a free and confidential quotation without obligation, please give the following information:

Name:		First	Initials	Last	Contact Telephone No:
Arrival date:	month	day	yr	Total number in party:	How will you travel to Boston?
Departure date:	month	day	yr	adults:	Air
				children:	Rail
Type of accommodation				Total rooms required:	Car
single room					
twin-bedded double					
family room					
junior suite					
parlor suite					
Approximate nightly budget per room (excluding meals)					
\$150 - \$200					
\$200 - \$250					
\$250 - \$300					
\$300 - \$400					
\$400+					
					please state any particular requirements: (special meals, adapted bathrooms, wheelchair access etc.)
					Near to any particular hospital? (if so please indicate which)
Address:					
City:					
State:					
Zip:					
Phone - Home:					
Work:					
Cell:					
email address:					
Fax:					

FIG. 14

PATIENT REFERRAL INFORMATION

DATE: ___/___/___

REFERRED BY:

(name) _____

(Phone) _____

(Dept.) _____

(Email) _____

PATIENT NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

DOB: _____

DIAGNOSIS/PROCEDURE:

BRIEF MH/ALLERGIES:

ESTIMATED LENGTH OF STAY / TREATMENT: _____ days

REFERRING HOSPITAL _____

FLOOR _____ UNIT _____ ROOM NUMBER: _____

SURGEON: _____ PHONE: _____ FAX: _____

SERVICES TO BE PROVIDED: _____

DATES/HOURS OF SERVICES: _____

Please check here to confirm that Page One/Two has been faxed

FIG. 15

10067087 050602

PATIENT REFERRAL INFORMATION

DATE: ___/___/___ REFERRED BY: (Name)_____
(Phone)_____
(Dept.)_____
(Email)_____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PHONE: _____ FAX: _____ CELL: _____

DIAGNOSIS/PROCEDURE: _____

BRIEF PMH/ALLERGIES: _____

ESTIMATED LENGTH OF OUTPATIENT TREATMENT: _____ days/weeks/months

REFERRING HOSPITAL _____ FLOOR _____ ROOM NUMBER: _____

SURGEON/PHYSICIAN _____ PHONE: _____ FAX: _____

SERVICES
REQUESTED: _____

START DATES/HOURS OF SERVICES: _____

Please check here to confirm that Page One/Two has been faxed

PAYMENT INFORMATION

Payment Guaranteed By: _____
Full Name: _____ (Relationship to Patient) _____

Address _____ Tel. No: _____

City _____ State _____ Zip _____ Email _____

METHOD OF PAYMENT: _____

CREDIT CARD DETAILS: _____

EXACT NAME ON CARD _____ EXPIRATION DATE _____

FIG. 16A

10067087 "050602"

SUPPLIES:

Prescriptions to be filled/delivered _____ YES (Please attach scripts) _____ NO

Medical supplies needed: _____

Medical/Adaptive equipment needed: _____

CONCIERGE SERVICES:

HOTEL

- ☐ Hotel preferences or price range: _____
- ☐ Number of Rooms: _____
- ☐ Number of Occupants: _____
- ☐ Arrival date/time: _____ (please note: most hotels have a 1p check in policy)
- ☐ Anticipated Date of Departure: _____

Room Preferences

BEDSIZE: _____ SMOKING/NON: _____ STANDARD/SUITE: _____

OTHER: _____

TRANSPORTATION:

- ☐ Nurse escort via car/airplane
- ☐ Wheelchair accessible van
- ☐ Ambulance
- ☐ Limousine
 - ☐ Pick up date, time, location: _____

AESTHETIC SERVICES:

- ☐ Massage: _____
- ☐ Facial: _____
- ☐ Manicure: _____
- ☐ Pedicure: _____
- ☐ Makeup application: _____
- ☐ Hair Services (Cut/wash/perm/set): _____

SPECIAL REQUESTS:

FIG. 16B

10067087 050602

[illegible]

Patient Name. _____
DOB _____

PHYSICIAN ORDERS

- ☐ New Admission Orders ☒ Monthly Renewal ☐ Telephone Order Verification
☐ Change in Plan of Care ☐ Change in Patient Status

[illegible]

RN/Clinician's Signature _____

Physician Name _____ Address _____
City, State, Zip _____
Physician's Signature _____ Date _____
Reply: _____

FIG. 18

MÉDICATION RECORD

ALLERGIES _____

Patient _____

	MEDICATION		DATE	DATE	DATE	DATE	DATE	DATE	DATE
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							
START		A							
D/C		M							
RED		P							
		M							

INIT	SIGNATURE	INIT	SIGNATURE

10067087 050602

FIG. 19A

PATIENT INTAKE FORM

PATIENT NAME: _____ DOB: _____

GUARDIAN NAME (IF CHILD): _____

PRIMARY PHYSICIAN: _____

DIAGNOSIS: _____

ALLERGIES: _____

CURRENT ADDRESS: _____

LOCAL PHONE# CELLULAR/ PAGER: _____

RELIGION: _____

COUNTRY OF ORIGIN: _____

PERMANENT MAILING ADDRESS: _____

PRIMARY LANGUAGE: _____

METHOD OF PAYMENT: _____

SOURCE OF REFERRAL: _____

NAME AND # OF PERSON CALLING IN CASE: _____

DATE OF ADMISSION: _____ DATE OF DISCHARGE: _____

START DATE OF SERVICES: _____

10067087 050602

209050 48079001

DOCTORS ORDERS: _____

ANTICIPATED LENGTH OF TREATMENT: _____

ADDITIONAL THERAPIES:

☐ OCCUPATIONAL THERAPY: _____

☐ PHYSICAL THERAPY _____

☐ SPEECH THERAPY: _____

☐ RESPIRATORY THERAPY: _____

☐ INFUSION SERVICES: _____

☐ ESCORTING TO APPOINTMENTS: _____

☐ SCHEDULE FOLLOW UP APPT: _____

☐ TRANSPORTATION: _____

☐ LIVING ACCOMODATIONS: _____

☐ OTHER: _____

DATE/TIME/SIGNATURE OF INTAKE WORKER: _____

PRIMARY NURSE ASSIGNED TO CASE: _____

FIG. 19B

FIG.20

CONCIERGE

☐ HOTEL: _____ ARRIVAL: _____ DEPARTURE: _____

ROOM PREFERENCES:

BEDSIZE: _____ SMOKING: _____ STANDARD/SUITE: _____

OTHER PREFERENCES: _____

☐ TRANSPORTATION:

PICKUP DATE/TIME/LOCATION: _____

☐ MEALS: _____

☐ AESTHETIC SERVICES:

☐ MASAGE: _____

☐ FACIALS: _____

☐ MAINCURE: _____

☐ PEDICURE: _____

☐ MAKEUP APPLICATION: _____

☐ OTHER: _____

COMMENTS: _____

FOR OFFICE USE ONLY (PLEASE INITIAL WHEN COMPLETED)

- | | |
|--|-------|
| <input type="checkbox"/> STAFF ASSIGNED: | _____ |
| <input type="checkbox"/> HOTEL BOOKED: | _____ |
| <input type="checkbox"/> TRANSPORTATION CONFIRMED | _____ |
| <input type="checkbox"/> PATIENT NOTIFIED OF ALL DETAILS IN WRITING: | _____ |
| <input type="checkbox"/> CONTACT MADE WITH SURGICAL TEAM: | _____ |
| <input type="checkbox"/> PATIENT INVOICED: | _____ |
| <input type="checkbox"/> FOLLOW UP LETTER SENT TO PATIENT: | _____ |
| <input type="checkbox"/> FOLLOW UP LETTER SENT TO PHYSICIAN: | _____ |

10067087-050602

FIG. 21

[illegible]

INIT	SIGNATURE	INIT	SIGNATURE

3009037 050606

209050 " 28049001

PATIENT TIME SHEET: NURSING
Fig. 23

Month _____
Patient Name _____
Location _____
Patient Signature _____
Staff Signature _____

Date of Mo	SUN			MON			TUE			WED			THUR			FRI			SAT			SUN		
	Nurse Name	Time In	Time Out	Total Hours	Nurse Name	Time In	Time Out	Total Hours	Nurse Name	Time In	Time Out	Total Hours	Nurse Name	Time In	Time Out	Total Hours	Nurse Name	Time In	Time Out	Total Hours	Nurse Name	Time In	Time Out	Total Hours
1		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
2		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
3		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
4		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
5		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
6		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
7		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
8		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
9		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
10		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
11		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
12		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
13		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
14		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
15		am	pm			am	pm			am	pm			am	pm			am	pm			am	pm	
Totals					Totals					Totals					Totals					Totals				

Applicant: Sternlicht

FIG. 24A

**PHYSICAL THERAPY
Initial Evaluation**

Date:

Name	Physician
Parent	Case Manager
Address	Primary PT
Date of Birth	Chief complaint
Gestational age	
Diagnosis	

SUBJECTIVE

PMH:

Social hx

Prior level of functioning:

Precautions:

Hx of present illness:

Pain

Medications

100637087 "050602"

MUSCULOSKELETAL ASSESSMENT					
Joint range of Motion <input type="checkbox"/> WNL					
Motion	Position	Mon		Arom	
		Right	Left	Right	Left
Muscle Strength <input type="checkbox"/> WNL					
Muscle	Position	Grade			
		Right	Left		
Muscle Tone					
Sensory					
REFLEX PROFILE					
Supine					
Prone					
Sitting					
Quadruped					
Standing/vertical Suspension					
Horizontal Suspension					

FIG. 24B

10067087 050600

Prone			
Supine			
Sitting			
Quadruped			
Kneeling			
Half Kneeling			
Standing			
Ambulation			
Stair Climbing			
Ball Skills			
Balance		Static	Dynamic
	Standing		
	Sitting		

FIG. 24c

10067087 "050602

FINE MOTOR ASSESSMENT
Focus/Visual Tracking
Approach
Grasp
Manipulation
Release
Transferring
Bilateral Activities
ACTIVITIES OF DAILY LIVING
Feeding
Dressing
Hygiene

FIG. 24D

209050 " 2307900T

EQUIPMENT	
SUMMARY	
Assessment:	Problems:
Plan of Care:	Goals:
Expected Visits	
Signature _____	PT _____ Date _____

FIG. 24E

209050" 28029007

FIG. 25

PATIENT TIME SHEET: THERAPY VISITS

Month _____		Patient Signature _____	
Patient Name _____		Staff Signature _____	
Location _____			

Date of Mo	SHIFT 1				SHIFT 2				SHIFT 3				
	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours	Therapist Name	Time In	Time Out	Total Hours	
1		am	pm			am	pm			am	pm		
2		am	pm			am	pm			am	pm		
3		am	pm			am	pm			am	pm		
4		am	pm			am	pm			am	pm		
5		am	pm			am	pm			am	pm		
6		am	pm			am	pm			am	pm		
7		am	pm			am	pm			am	pm		
8		am	pm			am	pm			am	pm		
9		am	pm			am	pm			am	pm		
10		am	pm			am	pm			am	pm		
11		am	pm			am	pm			am	pm		
12		am	pm			am	pm			am	pm		
13		am	pm			am	pm			am	pm		
14		am	pm			am	pm			am	pm		
15		am	pm			am	pm			am	pm		
Totals													

Fig. 26

PHYSICIAN MEMORANDUM

Date: _____

Physician: _____ Office/Fax: _____

Patient: _____ DOB: _____

☐ Patient Status Update

☐ Additional Service Request

☐ Orders

☐ Other

Comments:

R.N./Clinicians Name _____ Contact Number: _____

Reply:

Physician's Signature: _____ Date: _____

10067087.050603

FIG. 27

NAME AGE ALLERGIES		CV		RESP		TEACHING / PARENTS	
HISTORY							
DEVELOPMENT		NUTRITION		ELIMINATION		APPOINTMENTS	
		Central		U/O			
		PGT		Vomit			
		PO		Stool			
		Weight		Other			
SKIN / DSGS		Mouthcare				ISSUES TO RESOLVE	

FIG. 28A

PATIENT INFORMATION (FILL IN BY THE PATIENT)			NURSE'S ASSESSMENT																						
1. What language do you speak? _____ 2. Why do you need home care services? _____ 3. Do you have ALLERGIES to medicines/ latex/ food? If yes, list _____ 4. What is the hospital you are being treated at? _____ 5. Who is your primary doctor? _____ 6. Are there other doctor's involved in your care? _____ 7. Do you smoke? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____ 8. Do you use recreational drugs? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____ 9. Do you use alcohol? <input type="checkbox"/> no <input type="checkbox"/> yes How much? _____ 10. Please list all medications you are presently taking below <table border="1" style="width: 100%;"> <thead> <tr> <th>Medication</th> <th>Dose</th> <th>Purpose</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			Medication	Dose	Purpose																			HEALTH PERCEPTION MANAGEMENT <input type="checkbox"/> Needs health teaching <input type="checkbox"/> Needs med teaching	
Medication	Dose	Purpose																							
11. Do you have enough information about your medications? <input type="checkbox"/> no <input type="checkbox"/> yes 12. Do you have any problems with your bowels? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____ 13. Do you have any problems with urinating? _____			ELIMINATION <input type="checkbox"/> Needs output regimen																						
14. Do you have any problems with your intake of food? (eating, swallowing, chewing, nausea/vomiting)? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____ 15. Do you follow any special diets? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____ 16. Does you have any skin problems? (rashes, bruises, reactions, cut, bumps)? <input type="checkbox"/> no <input type="checkbox"/> yes Please describe _____			NUTRITION/METABOLIC <input type="checkbox"/> Needs nutrition teaching <input type="checkbox"/> Needs nutrition material																						
17. Are there any limitations to your activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ 18. Do you need assistance with any daily activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ 19. Do you have or need any special equipment? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____			ACTIVITY/EXERCISE <input type="checkbox"/> PT needed <input type="checkbox"/> OT needed																						

10067087 050602

20. Do you have any problems sleeping? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ _____	SLEEP/REST
21. Do you have enough energy for your daily activities? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ _____	COGNITIVE/ PERCEPTUAL
22. Do you have any problems with <input type="checkbox"/> memory <input type="checkbox"/> vision <input type="checkbox"/> hearing? Describe _____ _____	SEXUALITY/ REPRODUCTIVE
23. Do you any questions or concerns about your sexuality/reproductive system? <input type="checkbox"/> no <input type="checkbox"/> yes List _____ _____	COPING/STRESS
24. How are you coping with your health issues at the present time? _____ _____	SELF PERCEPTION
25. Has your illness changed your life significantly? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ _____	ROLE/RELATIONSHIP
26. Who are the important people to be involved in your care? _____ 27. Who shall we contact in the event of any emergency? Telephone _____ 28. Do you have a health care proxy? <input type="checkbox"/> no <input type="checkbox"/> yes name _____	<input type="checkbox"/> Proxy in chart
29. Are there any religious practices that we can support? <input type="checkbox"/> no <input type="checkbox"/> yes Describe _____ _____	VALUE/BELIEF
30. Are there any needs medically and personally that we can assist you with? <input type="checkbox"/> no <input type="checkbox"/> yes List _____ _____	
<p style="text-align: center;">NURSING ISSUES TO BE ADDRESSED</p> <p>Information obtained from _____</p> <p>Nursing Signature _____ Date _____</p>	

Progress Note

FIG. 29

[illegible]

Introduction